

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

41042

File No. **5030**
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATHCounty JacksonRegistration District No. 3 ETownship KawPrimary Registration District No. 306City Kansas City, Mo.(No. 204 East 80th Terrace)**2. FULL NAME** Thomas H. Clouser(a) Residence, No. 204 East 80th Terrace St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS**3. SEX****Male****4. COLOR OR RACE****White****5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)****Married****5A. IF MARRIED, WIDOWED, OR DIVORCED**HUSBAND OF
(OR) WIFE OF**Belle Clouser****6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb. 1, 1870**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1
day, _____ hrs.
or _____ min.**61****10****17****8. OCCUPATION OF DECEASED**(a) Trade, profession, or
particular kind of work**Carpenter**(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Missouri

(STATE OR COUNTRY)

PARENTS**10. NAME OF FATHER** Unknown**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Unknown**12. MAIDEN NAME OF MOTHER** Unknown**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Unknown**14. INFORMANT** Mrs. Belle Clouser

(Address)

204 E-80th Avenue**15.**

FILED

7/21/31 M. M. Croome

REGISTRAR

MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 12-18 1931**17. I HEREBY CERTIFY** Deputy Coroner That I attended deceased from _____

that I last saw him _____ alive on _____, 19____, to _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:Mental Stress**CONTRIBUTORY (SECONDARY)****18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Deputy Coroner M. D.1/18, 1931 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL**Dearborn, Mo.****DATE OF BURIAL****12-20-31** 19**20. UNDERTAKER****R.V. Lindsey & Sons, Inc.****ADDRESS****K. C. Mo.**

